



Complete the Request to Withdraw a Hearing Request (Form HA-85)

Instructions for Claimant/Representative

This online service allows either the claimant or the appointed representative to withdraw a hearing request. To complete the form online, you will need the valid email address of the person completing the form.

IMPORTANT: We will not process the form until you complete the form, **sign the form electronically**, and select “**Click to Sign**” to submit the form.

Before beginning the form, you (the person completing the online form) will enter and confirm your email address in the online application. You will also create a password that will be required for you to access the form.

You will receive an email from adobesign@adobesign.com containing a link and instructions on how to access the form.

NOTE: The form must be electronically signed and submitted within **five (5) calendar days** of initiating the process online (i.e., when you enter your email address in order to receive an email with a link to the form).

After successful submission of the form, you will be able to save a copy of the completed form within the application. You will also receive an email from adobesign@adobesign.com with a link to the completed form. You will need your pre-established password to save a copy for your records.

If you are the claimant and have an appointed representative, you should provide a copy of the completed form you saved to your representative. If you are the appointed representative, you should provide a copy of the completed form you saved to your client.

PLEASE NOTE:

- This website is most compatible with the following browsers: Microsoft Edge and Google Chrome.
- When accessing the form, the system will end your session after 60 minutes of inactivity. Use the link in your email and your pre-established password to continue working on your form.
- A daily email reminder will be sent until the form has been submitted or until the time expires (i.e., five (5) calendar days after initiation).
- **You will have to start a new form by returning to this website if *any* of the following situations apply:**
 - You forget or lose the password. The password cannot be reset.
 - You do not receive an email notification within a few minutes of your online submission. Be sure to check your junk folder.
 - You do not electronically sign and submit the form within five (5) calendar days.

Sections 205(a), 1631(d)(1), and 1872 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate determination regarding your request to withdraw your request for a hearing.

We will use the information you provide to decide if dismissing your hearing request is appropriate. We may also share your information for the following purposes, called routine uses:

- To a congressional office in response to an inquiry from that office made at the request of a subject of a record; and
- To a contractor or other Federal agency to assist in the efficient administration of our programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act Systems of Records Notices (SORN) 60-0005, entitled Administrative Law Judge Working File on Claimant Cases, as published in the Federal Register (FR) on April 29, 2009, at 74 FR 19617; and 60-0009, entitled Hearings and Appeals Case Control System, as published in the FR on October 13, 1982, at 47 FR 45589. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

*** I understand and agree to the above statement**

Start Application



Request to Withdraw a Hearing Request

We recommend that you verify the accuracy of your email address and make note of your password prior to submission.

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Your Email Address

Confirm Your Email Address

Document Name

Password Required

Password must contain at least 8 characters, 1 uppercase, 1 lowercase, and 1 number.

Show Password

Completion Deadline

Submit



Social Security

Request to Withdraw a Hearing Request

To complete the online form, open the email from adobesign@adobesign.com and click on the "Review and sign" button.



Mon 6/7/2021 2:58 PM


Social Security Administration <adobesign@adobesign.com>

[EXTERNAL] Social Security Administration Has Sent You Request to Withdraw a Hearing Request to Sign

To Claimant Email Address

Retention Policy Delete_7_Year_Default (7 years)

Expires 6/5/2028

 If there are problems with how this message is displayed, click here to view it in a web browser.



Social Security Administration requests your signature Request to Withdraw a Hearing Request

Form Expires On June 12, 2021

[Review and sign](#)

THIS LINK EXPIRES IN FIVE (5) CALENDAR DAYS.

You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. If you forget or lose the password, you will have to restart the process.

You will have to start a new form if you forget or lose your password, or if you do not electronically sign and submit the form within five (5) calendar days. The password cannot be reset. To start a new form, please visit <https://ssa.gov/ha85-online-form>.

The "Review and sign" link is personalized for you and, for security purposes, we recommend that you do NOT forward/share this email or link with others. If you DO forward/share this email or link with others, you accept the risk that, by sharing your personal information, the person assisting you may misuse your personal information. If you have any questions about this email or feel that you received this in error, please contact SSA at 1-800-772-1213 (TTY 1-800-325-0778) between 8:00 am – 7:00 pm, Monday through Friday.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit <https://oig.ssa.gov/report> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-800-501-2101).

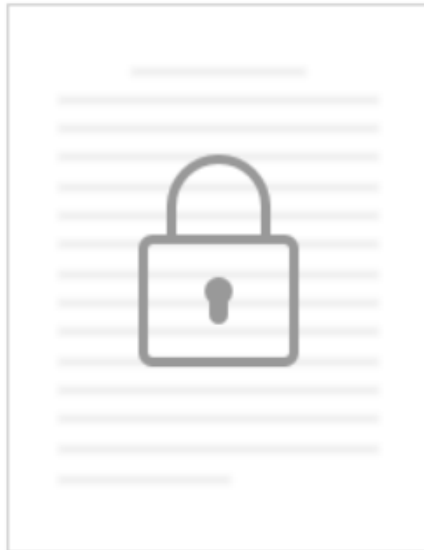
SOCIAL SECURITY ADMINISTRATION



By proceeding, you agree that this agreement may be signed using electronic or handwritten signatures.

To ensure that you continue receiving our emails, please add adobesign@adobesign.com to your address book or safe list.

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This Document is Password Protected

You need a password to access this document. If you don't have a password, you will need to contact [Social Security Administration](#) to obtain it.

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0710

REQUEST TO WITHDRAW A HEARING REQUEST

IMPORTANT NOTICE - This is a request to withdraw your hearing request. The judge will consider this request and decide if dismissing your hearing request is appropriate. If we deny your request, the hearing process will go on as if you had not filed this form. If we approve this request, the hearing process will stop. We will send you a dismissal notice and we will not process your case. The last determination in your case will stay in effect. If you change your mind, you must ask the judge to cancel this request to withdraw within 60 days after you get the dismissal notice. You must give a good reason why the dismissal was wrong. You may also file an appeal with the Appeals Council (AC) within 60 days after you get the dismissal notice. Even if you do not ask the judge to cancel your request, and do not file an appeal, the AC may set aside the dismissal of your hearing request. This would occur within 60 days after we mail the dismissal notice to you.

Do not write in this space



CLAIMANT NAME *		CLAIMANT SSN *	
WAGE EARNER NAME, IF DIFFERENT (or, if applicable, name of surviving eligible spouse or other individual eligible to receive benefits due a deceased claimant)		CLAIMANT CLAIM NUMBER, IF DIFFERENT	
PRINT YOUR NAME (First name, middle initial, last name)	DATE OF HEARING REQUEST	BENEFIT APPLIED FOR	
	TYPE OF CLAIM(S)		

I wish to withdraw my hearing request. My request is voluntary. I understand the effects of this request. Namely, a judge may dismiss my hearing request. If the judge does, the last determination in my case will stay in effect, unless the dismissal is set aside. This may result in the potential loss of benefits. I understand that I have 60 days from when I get the dismissal notice to cancel my request or file an appeal with the Appeals Council. My decision affects no other potential parties to my knowledge. I understand that all items relating to my claim will be part of SSA's records.

Give reason for withdrawal. (If you need more space, use the reverse of this form.)
*

Continued on reverse

SIGNATURE OF PERSON MAKING REQUEST (OPTIONAL)

Signature (First name, middle initial, last name) (Write in ink)	Date (Month, day, year)
SIGN HERE * Click here to sign	Telephone Number (Include area code) *

Mailing Address (Number And Street, Apt. No., PO Box, Or Rural Route)
*

City and State *	ZIP Code *	Enter Name of County (if any) in which you now live
----------------------------	----------------------	--

Witnesses are required ONLY if this request has been signed by a mark (X) above. If signed by a mark (X), two witnesses to the, signing, who know the person making the request, must sign below. Both witnesses must give their full address.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, ZIP Code)	Address (Number and Street, City, State, ZIP Code)



Type



Draw



Mobile



Sign

Test Claimant

Clear

Close

Apply

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0710

REQUEST TO WITHDRAW A HEARING REQUEST

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Do not write in this space

CLAIMANT NAME Test Claimant		CLAIMANT SSN 123456789	
WAGE EARNER NAME, IF DIFFERENT <i>(or, if applicable, name of surviving eligible spouse or other individual eligible to receive benefits due a deceased claimant)</i> Additional Name		CLAIMANT CLAIM NUMBER, IF DIFFERENT 123123A	
PRINT YOUR NAME <i>(First name, middle initial, last name)</i> Test Claimant	DATE OF HEARING REQUEST 01/01/2020	BENEFIT APPLIED FOR Test	
	TYPE OF CLAIM(S) Test		

I wish to withdraw my hearing request. My request is voluntary. I understand the effects of this request. Namely, a judge may dismiss my hearing request. If the judge does, the last determination in my case will stay in effect, unless the dismissal is set aside. This may result in the potential loss of benefits. I understand that I have 60 days from when I get the dismissal notice to cancel my request or file an appeal with the Appeals Council. My decision affects no other potential parties to my knowledge. I understand that all items relating to my claim will be part of SSA's records.

Give reason for withdrawal. (If you need more space, use the reverse of this form.)

Test Information

Continued on reverse

SIGNATURE OF PERSON MAKING REQUEST (OPTIONAL)

Signature <i>(First name, middle initial, last name) (Write in ink)</i> SIGN <u>Test Claimant</u> HERE Test Claimant (Jun 7, 2021)	Date <i>(Month, day, year)</i> Jun 7, 2021
	Telephone Number <i>(Include area code)</i> +11112223333

Mailing Address *(Number And Street, Apt. No., PO Box, Or Rural Route)*
123 Test Street

City and State Test	ZIP Code 11111	Enter Name of County <i>(if any) in which you now live</i>
-------------------------------	--------------------------	---

Witnesses are required ONLY if this request has been signed by a mark (X) above. If signed by a mark (X), two witnesses to the, signing, who know the person making the request, must sign below. Both witnesses must give their full address.

1. Signature of Witness	2. Signature of Witness
Address <i>(Number and Street, City, State, ZIP Code)</i>	Address <i>(Number and Street, City, State, ZIP Code)</i>

SSN: 123456789

Additional Remarks:

Large empty yellow rectangular area for additional remarks.

FOR USE OF SOCIAL SECURITY ADMINISTRATION

<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED BECAUSE	<input type="checkbox"/> CLAIMANT DOES UNDERSTAND CONSEQUENCES	<input type="checkbox"/> WITHDRAWAL WOULD HARM INTEREST OF CLAIMANT OR OTHER PARTIES	<input type="checkbox"/> OTHER <i>(Attach explanation)</i>
SIGNATURE OF SSA EMPLOYEE		TITLE	<input type="checkbox"/> JUDGE <input type="checkbox"/> OTHER (Specify)	DATE

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 1631(d)(1), and 1872 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate determination regarding your request to withdraw your request for a hearing.

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- To a contractor or other Federal agency to assist in the efficient administration of our programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

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Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments relating to our time estimate above to:** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.



You're all set

You finished signing "Request to Withdraw a Hearing Request".

All parties will be notified via email. You can also [download a copy](#) of what you just signed.

Mon 5/17/2021 3:49 PM

Social Security Administration <adobesign@adobesign.com>

[EXTERNAL] Request to Withdraw a Hearing Request has been Signed and Filed

To Claimant Email Address

Retention Policy Delete_7_Year_Default (7 years)

Expires 5/15/2028

 If there are problems with how this message is displayed, click here to view it in a web browser.



Social Security



You're done signing
Request to Withdraw a Hearing Request

[Open Document](#)

The document is complete.

You can [open the final document](#) to review its activity history or download a copy for reference.

For additional security, you have set a password for this document. You will need the password to review this document. If you forgot or lose the password, it cannot be reset.

This link is personalized for you and, for security purposes, we recommend you do NOT forward/share this email or link with others. If you DO forward/share this email or link with others, you accept the risk that, by sharing your personal information, the person assisting you may misuse your personal information. If you have any questions about this [email](#) or feel that you received this in error, please contact SSA at 1-800-772-1213 (TTY 1-800-325-0778) between 8:00 am – 7:00 pm, Monday through Friday.

The document is fully executed. The Social Security Administration has control over the retention period for this document which determines the amount of time it will be available for download from Adobe Sign. Adobe recommends that you save a local copy of this fully-executed document for your records.



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Request to Withdraw a Hearing Request

Created Jun 07, 2021 2:58 PM




From: Social Security Administration
(no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIVE (5) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. If you forget or lose the password, you will have to restart

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Actions

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-  Add Notes

> 1 Recipient (1 Completed)

> Activity

Password Required

This file is password protected. To access it, please enter the password.

Cancel

Submit

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0710

REQUEST TO WITHDRAW A HEARING REQUEST

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Do not write in this space

CLAIMANT NAME Test Claimant		CLAIMANT SSN 123456789	
WAGE EARNER NAME, IF DIFFERENT <i>(or, if applicable, name of surviving eligible spouse or other individual eligible to receive benefits due a deceased claimant)</i> Additional Name		CLAIMANT CLAIM NUMBER, IF DIFFERENT 123123A	
PRINT YOUR NAME <i>(First name, middle initial, last name)</i> Test Claimant	DATE OF HEARING REQUEST 01/01/2020	BENEFIT APPLIED FOR Test	
	TYPE OF CLAIM(S) Test		

I wish to withdraw my hearing request. My request is voluntary. I understand the effects of this request. Namely, a judge may dismiss my hearing request. If the judge does, the last determination in my case will stay in effect, unless the dismissal is set aside. This may result in the potential loss of benefits. I understand that I have 60 days from when I get the dismissal notice to cancel my request or file an appeal with the Appeals Council. My decision affects no other potential parties to my knowledge. I understand that all items relating to my claim will be part of SSA's records.

Give reason for withdrawal. (If you need more space, use the reverse of this form.)

Test Information

Continued on reverse

SIGNATURE OF PERSON MAKING REQUEST (OPTIONAL)

Signature <i>(First name, middle initial, last name) (Write in ink)</i> SIGN <u>Test Claimant</u> HERE Test Claimant (Jun 7, 2021 15:12 EDT)	Date <i>(Month, day, year)</i> Jun 7, 2021
Telephone Number <i>(Include area code)</i> +11112223333	

Mailing Address *(Number And Street, Apt. No., PO Box, Or Rural Route)*
123 Test Street

City and State Test	ZIP Code 11111	Enter Name of County <i>(if any) in which you now live</i>
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1. Signature of Witness	2. Signature of Witness
Address <i>(Number and Street, City, State, ZIP Code)</i>	Address <i>(Number and Street, City, State, ZIP Code)</i>

Request to Withdraw a Hearing Request

Created Jun 07, 2021 2:58 PM

From: Social Security Administration
(no-reply@ssa.gov)

Status: Signed

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Actions

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> 1 Recipient (1 Completed)

> Activity

SSN: 123456789

Additional Remarks:

Request to Withdraw a Hearing Request

Created Jun 07, 2021 2:58 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

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Actions

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> 1 Recipient (1 Completed)

> Activity

FOR USE OF SOCIAL SECURITY ADMINISTRATION

APPROVED NOT APPROVED BECAUSE CLAIMANT DOES UNDERSTAND CONSEQUENCES WITHDRAWAL WOULD HARM INTEREST OF CLAIMANT OR OTHER PARTIES OTHER (Attach explanation)

SIGNATURE OF SSA EMPLOYEE TITLE JUDGE OTHER (Specify) DATE

Form HA-85 (01-2014)

Page 2



2 / 3





Privacy Act Statement Collection and Use of Personal Information

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Request to Withdraw a Hearing Request

Created Jun 08, 2021 3:45 PM

From: Social Security Administration (85 Dev) (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIVE (5) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. If you forget or lose the password, you will have to restart the process. You will have to start a new form if you forget or lose your password, or if you

[See more](#)

Actions

- Download PDF
- Download Audit Report
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> 1 Recipient (1 Completed)

> Activity